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November 7, 2017

VIA ELECTRONIC FILING

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th Street, S.W., Room TW-B204
Washington, DC 20554

Re: Notice of *Ex Parte* in WC Docket No. 02-60

Madam Secretary:

In accordance with Section 1.1206 of the Commission's rules, 47 C.F.R. § 1.1206, we hereby provide notice of an oral and written *ex parte* presentation in connection with the above-captioned proceeding. On Friday, November 3, 2017, Tom Reid of Reid Consulting, Project Coordinator for the Southern Ohio Health Care Network (SOHCN),[1] and undersigned counsel, met separately with Jay Schwarz, Legal Advisor to Chairman Pai, Travis Litman, Legal Advisor to Commissioner Rosenworcel, Jamie Susskind, Chief of Staff for Commissioner Carr, and Amy Bender, Legal Advisor to Commissioner O'Rielly. We also met with the following individuals in the Wireline Competition Bureau: Ryan Palmer, Division Chief, Telecommunications Access Policy Division (TAPD), Radhika Karmarkar, Deputy Division Chief, TAPD, and legal advisors Regina Brown, Dana Bradford, and Preston Wise.

The purpose of our meetings was to review SOHCN's success in utilizing Rural Health Care (RHC) pilot program funding to meet Commission objectives and address the dire needs of communities in rural southeastern Ohio for increased access to both broadband and health care. We also discussed SOHCN's migration this year to the FCC's Healthcare Connect Fund (HCF) and SOHCN participants' concerns regarding the predictability of funding in that program.

We noted that SOHCN is a signatory to the letter recently sent by the Schools, Health & Libraries Broadband (SHLB) Coalition asking Congress to support the FCC in increasing the funding cap for the RHC program. To ensure effective use of limited universal service funding, we discussed how the RHC program defines "rural" for purposes of health care provider eligibility, and how

[1] http://www.sohcn.org/

this is playing out in practice in southern Ohio. Attached please find a corrected copy of the slides we discussed in our meetings.

Sincerely,

Jeffrey A. Mitchell
Counsel for Adena Health System/SOHCN

Attachment

FCC Healthcare Connect Fund:

Oversubscription,
Unintentional Inclusion of Urban Providers,
Unintentional Exclusion of Rural Providers and
Proposed Solutions

Tom Reid

Project Coordinator – Board Appointed

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3 November 2017

Vision of the Southern Ohio Health Care Network (SOHCN)

- Founded in 2006 as a non-profit organization focused on Appalachian providers and patients to:
  - Expand access to world-class care
  - Improve health outcomes
  - Provide professional development for rural health care providers
- Board of Directors appointed from the consortium's rural healthcare provider membership

Broadband identified as a key missing ingredient

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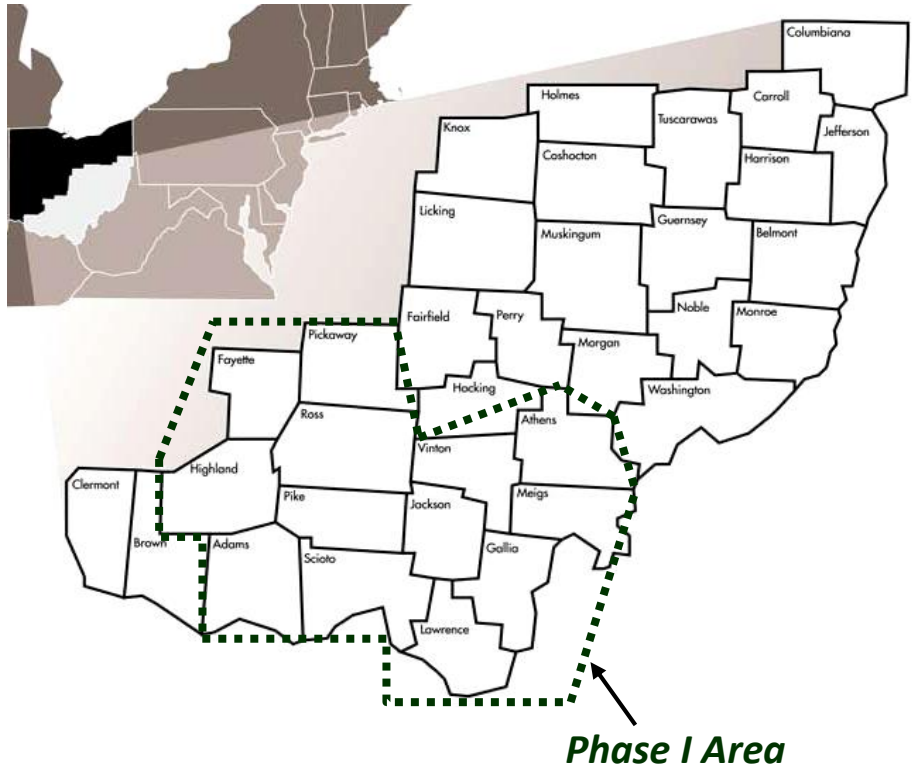
Phase I – FCC-Funded Project

- The SOHCN represents 34 rural Ohio counties
- Launched a 13-county carrier-partner fiber build in 2007
- The $30 million project was funded by:
  - FCC Rural Health Care Pilot Program
  - Adena Health System (fiduciary agent)
  - Horizon Telcom (winner of the competitive bidding)
- Serving 100+ locations owned by 12 health care providers
- Saving members more than $2 million per year



Fiber-based services now available to schools, libraries and businesses across the service area

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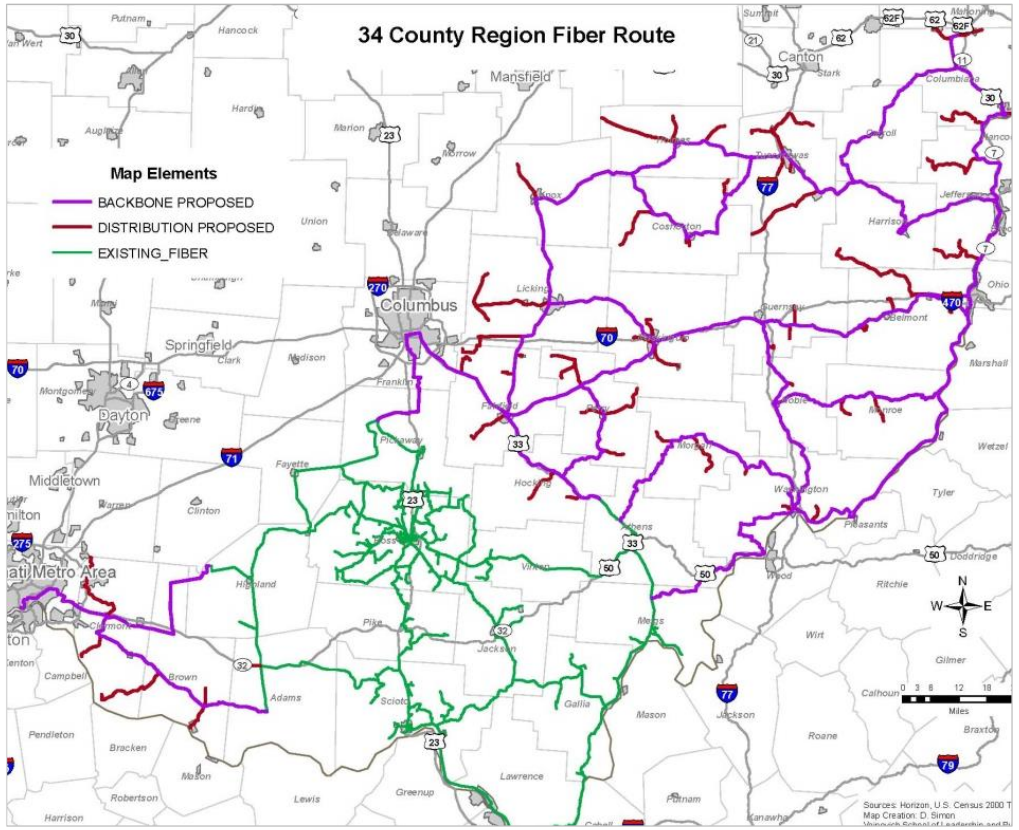
Phase II – Connecting Appalachia Project

- Connecting Appalachia initiative created by SOHCN and garnered unprecedented support from healthcare, K-12, economic development and local governments
- The $100 million project was funded by:
  - NTIA BTOP Program
  - Horizon Telcom (lead applicant)
- 1,400 miles of fiber built across Appalachian areas
- Hundreds of health systems, K-12, higher education and governmental sites connected
- Dozens of small communities now with fiber Ethernet availability
- Rapid expansion of mobile services due to fiber-to-the-tower access



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FCC Healthcare Connect Fund

- Provides a maximum 65% subsidy for broadband connections for rural healthcare providers
- "Rural" defined as census tracts that fall entirely outside an "urban cluster" with a population >25,000, 0% geographic overlap
- Consortia must contain a minimum of 51% rural locations (SOHCN currently at 86%)

Program Issues

1. Program oversubscription becoming a serious issue, reducing subsidy percentage
2. Urban health systems qualifying for subsidy meant for rural providers
3. Definition of rural disqualifying sites that should receive subsidy
4. Minor overlap with an "urban cluster" disqualifies large rural census tracts

SOHCN is signatory on Schools, Health & Libraries Broadband Coalition letter addressing these and other topics

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Lack of Differentiation

Chillicothe, Ohio (top)

- Population: 32K
- Economically distressed, isolated town
- 45 miles from closest metropolitan area (Columbus, Ohio)

Upper Arlington, Ohio (bottom)

- Population: 35K
- Affluent, metro-connected town
- Adjoining Columbus, Ohio with urban cluster population of 1.4M

Under Existing HCF Criteria

No differentiation between these two towns of very different circumstances – both designated as “urban”

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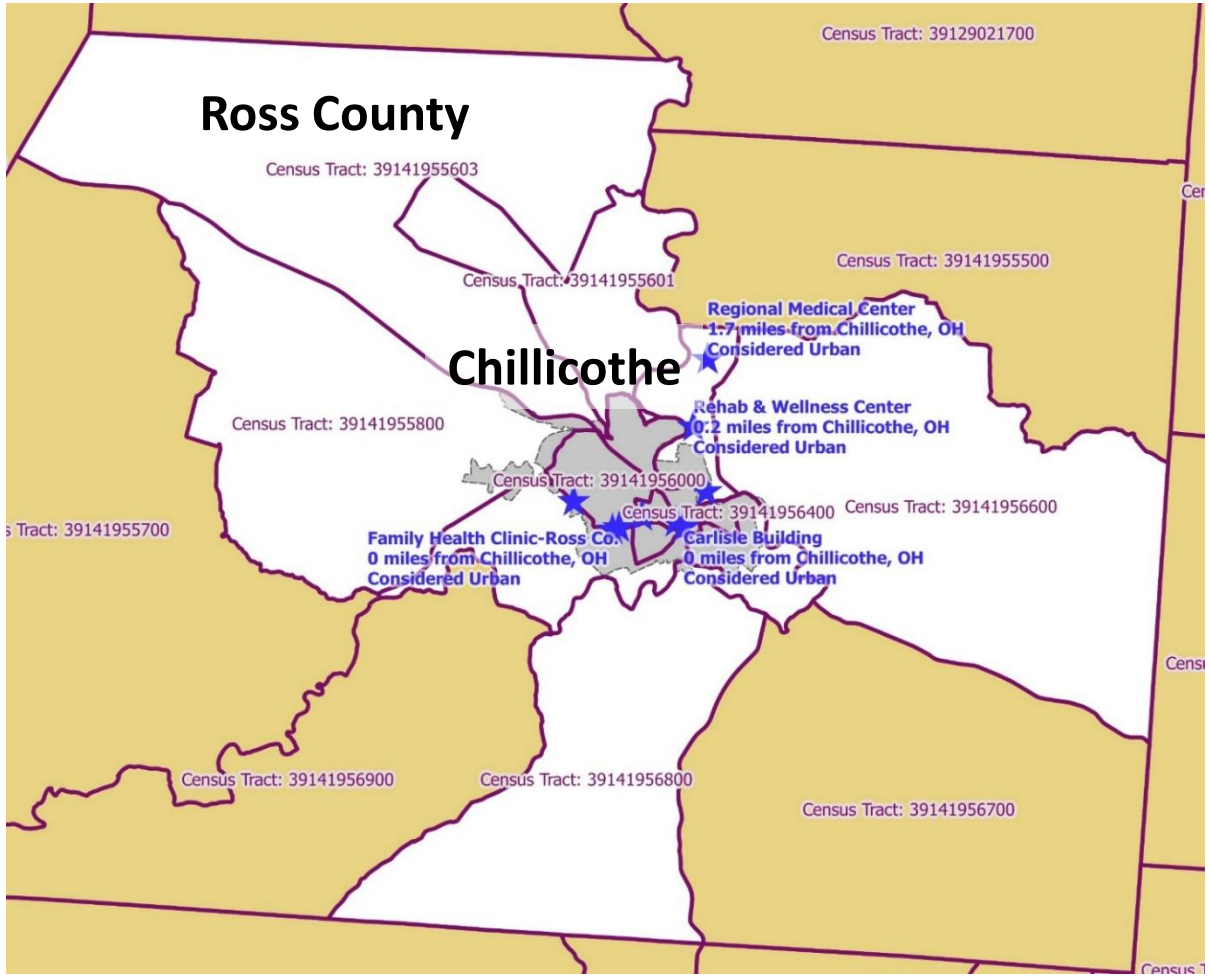
Unintended Consequences:
Excluding Rural Providers

Chillicothe, Ohio "Urban Cluster"
Population: 32K

- The slightest overlap with the Chillicothe "urban cluster" results in "urban" designations for large rural census tracts (white areas)
- Adena Health System facilities within Ross County, other than the main facility, would not normally qualify for the HCF subsidy
- Due to being "grandfathered" based on participation in the Pilot Program, these sites will receive subsidy
- Using Chillicothe as an example of a nationwide issue of how "rurality" designations can disqualify deserving provider sites



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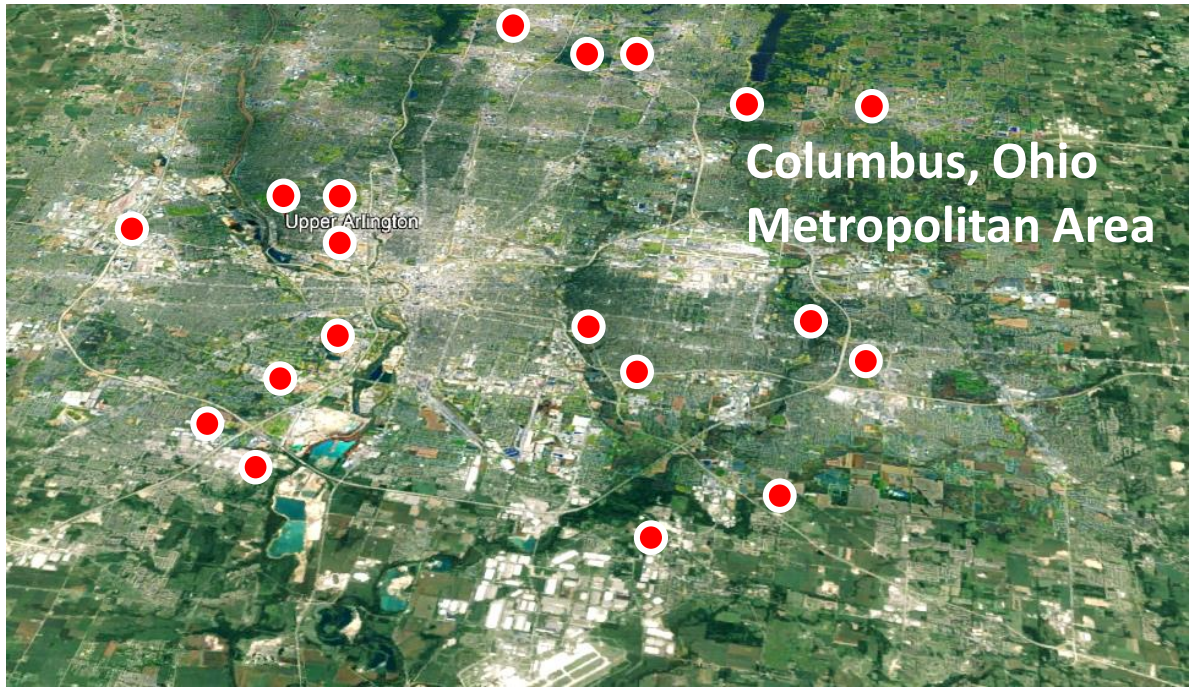
Unintended Consequences:
Inclusion of Urban Providers

Columbus, Ohio Urban Cluster
Population: 1.4 million

- SOHCN could admit, as an example, Mount Carmel Health System into our HCF-consortium
- Mount Carmel main location then automatically qualifies for HCF subsidy due to membership
- With Mount Carmel using point-to-point networking most of their urban sites qualify, including those in Upper Arlington, because one end of the circuit is at an eligible facility
- Due to high percentage of rural facilities in SOHCN, these urban sites would receive HCF subsidy
- Urban-to-rural remote consultations only require connectivity to the main site of the urban provider



● Mount Carmel urban facilities (approximated locations)

Note: No accusation of wrong doing is intended. We simply use Mount Carmel as an example for illustration of the HCF program's issues.

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Issues Re-Cap and Proposed Modeling

Issues to Resolve

1. Program oversubscription becoming a serious issue, reducing subsidy percentage
2. Urban health system locations qualifying for subsidy beyond what is needed to support urban-to-rural consultations
3. Definition of rural disqualifying sites that should receive subsidy
4. Minor overlap with an "urban cluster" disqualifies large rural census tracts

Proposed Solution – "What If" Modeling in GIS-Enabled Database

- Run simulations with varied "what if" eligibility tweaks using detailed site data from existing and soon-to-be-issued HCF funding commitments, e.g.
  - Create "isolated community" criteria stipulating a minimum distance from a metro area (addresses 1., 2. and 3.)
  - Increase population cluster threshold to 50,000 from 25,000 (addresses 3. and 4.)
- Output "what if" models will provide both visual and tabulation outputs to inform the refinement of eligibility criteria and determination of funding levels required to meet program objectives

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